Figure 1

```
   ┌─────────────────┐                    ┌─────────────────┐
   │    Personal     │                    │    Medical      │
   │    Patient      │                    │    Patient      │
A  │  Information    │              C     │  Information     │
   │    Input        │                    │    Input         │
   └────────┬────────┘                    └────────┬────────┘
            │                                      │
            ▼                                      ▼
   ┌──────────────────────────────────────────────────────────┐
   │                     Central System                         │
   └──────────┬────────────────────────────────────┬──────────┘
              │                                     │
              ▼                                     ▼
      ┌───────────────┐                    ┌─────────────────────┐
      │    Patient    │                    │   Recommendations   │
  B   │   Analysis    │              D     │      Outcome        │
      │    Outcome    │                    │                     │
      └───────────────┘                    └─────────────────────┘
```

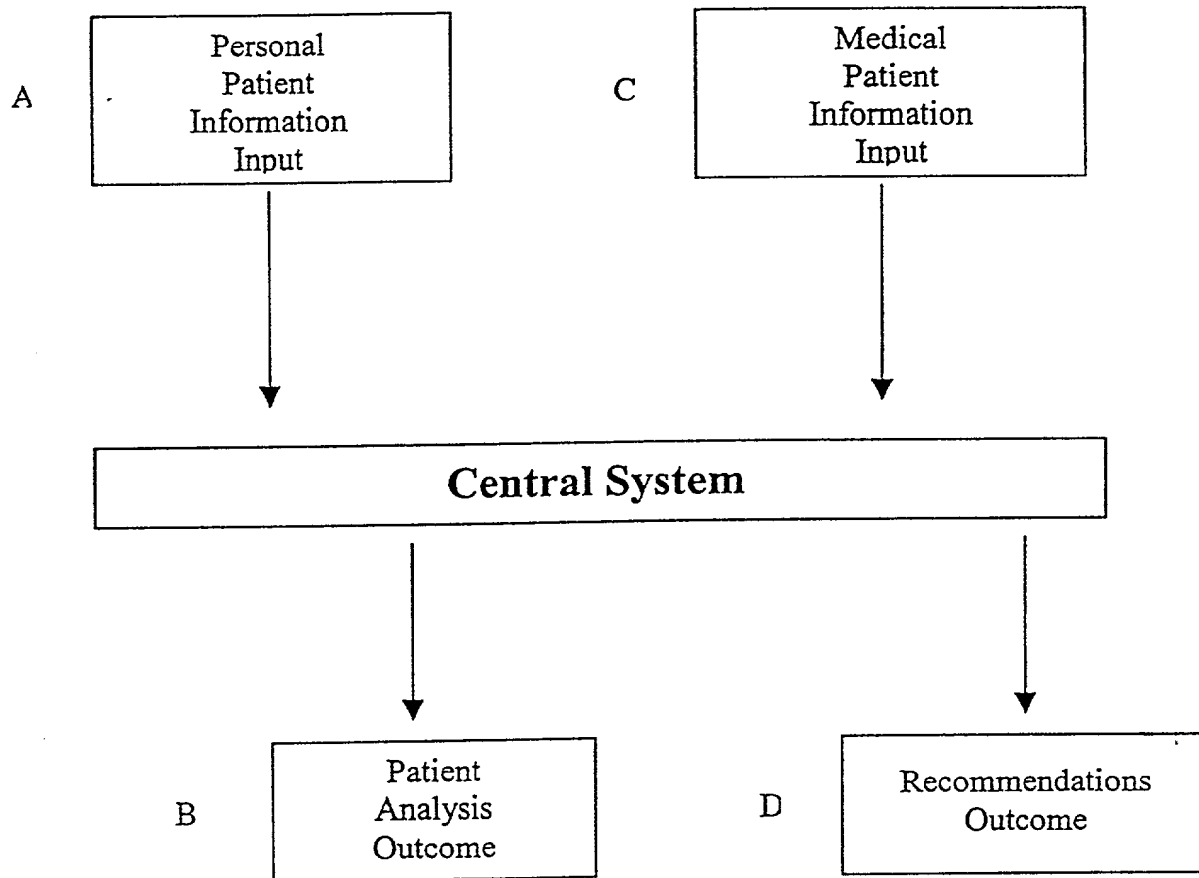# Figure 2

LifeMasters® CAD Program – Risk Assessment Survey

Section 1 – Patient/Physician Information   Please complete the following

Patient Name:		
What is the name of your physician:	Phone number if available:	
Is your physician a cardiologist:	☐ Yes	☐ No

Section II – Predictors of Coronary Artery Disease Risk   Please complete the following

What is your LDL cholesterol level("bad" cholesterol) ?	☐ More than 100 mg/dL	☐ 100 mg/dL or less
What is your HDL cholesterol level ("good" cholesterol)?	☐ More than 35 mg/dL	☐ 35 mg/dL or less
What is your triglycerides level?	☐ More than 200 mg/dL	☐ 200 mg/dL or less
Is your blood pressure 130/80 or higher?	☐ Yes	☐ No
Do you currently smoke cigarettes?	☐ Yes	☐ No
Do you have diabetes or do you take medicines to control your blood glucose?	☐ Yes	☐ No
Has your doctor told that you have problems with the arteries (blood vessels) in your heart?	☐ Yes	☐ No
Have you ever had a heart attack?	☐ Yes	☐ No
Has your doctor told you that you have an enlarged heart or heart failure?	☐ Yes	☐ No
Have you been admitted to the hospital or visited the emergency department in the previous 12 months for a heart problem?	☐ Yes	☐ No
Did a first-degree relative (father, mother, brother, sister, son or daughter) have a heart attack before the age of 55 years?	☐ Yes	☐ No

Figure 3

Dear [Healthcare Provider]:

<<customer>> is pleased to introduce the LifeMasters® Coronary Artery Disease (CAD) Primary Prevention program, a disease management intervention for <<customer>> patients. This innovative program was established to reduce the incidence of angina, myocardial infarctions and strokes in patients at high risk for coronary artery disease (CAD). LifeMasters' goal is to identify individuals who are at high risk for CAD and then support physicians in their care management of these patients. A high risk patient for CAD is defined by the American Heart Association an any individual with two or more cardiovascular risk factors (hypertension, hyperlipdemia, positive family history for CAD, current smoker, etc.) or having diabetes. Once a high risk patient is identified through an evidence-based risk assessment survey, the patient is enrolled in the following support program that facilitates the "best practice" management of that patient's CAD risk factors. This primary prevention program for at risk CAD patients consists of the following components:

1) All patients who are 45 years of age or older are identified via the health plan's membership data
2) These patients are sent the LM CAD risk assessment survey
3) Upon completion of these surveys, patients are identified who are at high risk for the development of coronary artery disease (CAD) as defined by the American Heart Association.
4) In order to promote best practice clinical management of these at-risk patients, the identified personal physician of these patients is sent a follow-up LM CAD data collection tool for completion of patient-specific clinical data
5) Upon return of this CAD data collection tool back to LM, the physician is sent a one page, patient-specific "best practice" set of recommendations based on the American Cardiology/American Heart Association clinical guidelines.
6) This patient-specific CAD data collection tool and recommendation report is then sent to the physician every six months so the physician can longitudinally track the care management progress of his/her at-risk patients for CAD.

Enclosed with this cover letter is a CAD data collection tool for each of the patients in your practice that have been identified as high risk for the development of CAD. We want to thank you beforehand for your timely completion of these clinical data forms and hope they will be helpful in tracking the care of your patients.

Please contact _____ with questions or feedback about the program. We appreciate your support and look forward to a successful program.

Sincerely,

LifeMasters Supported SelfCare, Inc.

Enclosure: CAD Data Collection Tool and

Figure 4

LifeMasters® CAD Program – Data Collection Form

Instructions:

Fill in the data collection date

Complete Section I: Correct the current information and/or supply missing information, as applicable

Complete Section II: Check the "Yes" or "No" checkboxes for all items as applicable

Complete Section III: Check the "Yes" or "No" checkboxes for all items as applicable

Date: _____

Section 1 – Patient/Physician Information

Patient Name:		AGE:	DOB:

Height:	Weight:

Physician Name:

Physician Address:

Physician Phone Number:	FAX Number:	Email:

Section II – Medical History /Risk Factors

			Yes	No
History of MI	Yes ☐ No ☐	Hospitalization for MI in last 12 months	☐	☐
History of CABG or angioplasty			☐	☐
History of angina pectoris			☐	☐
History of positive stress test (ECG stress test or echocardiography stress test)			☐	☐
History of diabetes			☐	☐
Most recent HbA1c level is $\geq$ 8%			☐	☐
History of hypertension	Yes ☐ No ☐	Is hypertension well controlled (BP $\geq$ 130/85, if diabetes BP > 130/80)	☐	☐
History of hyperlipdemia			☐	☐
LDL-c within the past 12 months	Yes ☐ No ☐	Is the LDL-c < 100 mg/dL ?	☐	☐
Triglycerides within the past 12 months	Yes ☐ No ☐	Is the triglycerides < 200 mg/dL?	☐	☐
HDL-c within past 12 months	Yes ☐ No ☐	Is the HDL-c $\geq$ 40 mg/dL	☐	☐
Current smoker			☐	☐
If the patient is a current smoker, is smoking cessation counseling given at every clinic appointment			☐	☐

Section III – Medication Profile

	Yes	No
Is the patient on antiplatelet therapy?	☐	☐
Is the patient on beta blocker therapy (if history of MI present)?	☐	☐
Is the patient on statin therapy?	☐	☐
Is the patient on nicotinic acid, fibrate or resin therapy	☐	☐

Fax the completed form to LifeMasters

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Figure 5

LifeMasters® CAD Program Recommendations

LifeMasters·

Report Date: _____ CAD Clinical Recommendations for John Doe (id:17). Based on data collected _____

Past Medical History: (1) MI (within last 12 months), (2) Angina, (3) Diabetes, and (4) Hypertension

These recommendations are intended to assist physicians in clinical decision making by describing a range of generally acceptable approaches for the management, or prevention of CAD.

Indicator	Goal	Goal Met	Recommendations
MI (within last 12 months)	β-blocker therapy initiated	No	**Post Recent MI** History of MI within last 12 months. No β-blocker medication reported. The ACC/AHA recommends the initiation of β-blocker therapy[1].
Antiplatelet Therapy	Antiplatelet therapy initiated	Yes	**Antiplatelet Therapy** Antiplatelet therapy reported. No additional recommendations.
Hypertension	BP< 130/85 (< 130/80 for diabetes)	No	**Hypertension** BP ≥130/85 reported. For uncomplicated hypertension, the JNC VI recommends the use of β-blocker and/or diuretics as first line therapy. As recommended by the ACC/AHA guidelines, for patients with known CAD titrate medication regimen to BP < 130/85 (for diabetic patients, titrate BP to < 130/80). If patient also diagnosed with diabetes or CHF, consider ACE inhibitor medication as first line therapy. If patient has NYHA class II or III CHF, also consider adding β-blocker therapy[4].
LDL-c	LDL-c < 100 mg/dL	No	**Elevated LDL-c** LDL-c level ≥ 100 mg/dL reported and patient on statin therapy. Recommend either titrating current medication, adding another lipid lowering medication or changing to alternative therapeutic regimen in order to achieve ACC/AHA recommended LDL-c level of < 100 mg/dL[1,2].
Triglycerides	Triglycerides < 200 mg/dL	No	**Elevated Triglycerides** Triglycerides level > 200 mg/dL reported. The ACC/AHA recommends gemfibrozil or niacin therapy for patients with HDL-c < 40 mg/dL and triglycerides level > 200 mg/dL, if no contraindications[1,2].
HDL-c	HDL-c ≥ 40	No	**Low HDL-c** HDL-c level < 40 mg/dL reported. Currently on lipid lowering medication. If accompanying triglycerides levels > 200 mg/dL, the ACC/AHA Recommends gemfibrozil or niacin therapy[1,2].
Diabetes	HbA1c < 8%	No	**Diabetes** HbA1c ≥ 8% reported. The ADA recommends a HbA1c goal < 7%. The findings of the DCCT and UKPDS studies indicate that strict blood glucose control will prevent up to 70% of significant, kidney, eye, and neurological complications. These studies also indicate that every percentage point decrease in an individual's HbA1c level there is a 25% reduction in diabetes-related deaths, a 7% reduction in all-cause mortality and an 18% reduction in combined fatal and nonfatal myocardial infarction[3].
Current Smoker	Non-smoker	Not Known	**Smoking Cessation** No response received. Assess the patient's smoking status and offer appropriate interventions if currently smoking[5].
Obesity	BMI < 27 Kg/m²	No	**Obesity** Regular exercise may reduce the risk of CAD Recommend low cholesterol, low fat diet

[1] AHA/ACC/ACP-ASIM Guidelines for the Management of Patients with Chronic Unstable Angina and Acute MI (2000)
[2] National Cholesterol Education Program (NCEP – ATPIII) – 2001
[3] American Diabetes Association 2001
[4] The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VI) – 1997
[5] Treating Tobacco Use and Dependence, U.S. Department of Heath and Human Services Clinical Guidelines – 2000

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